

Quality Data Model (QDM) User Group Meeting | AGENDA/MEETING MINUTES

Meeting date | 12/17/2014 2:30 PM EDT | Meeting location | Webinar video link: <https://www4.gotomeeting.com/register/303510935>

Attendees: Yvette Apura, Balu Balasubramanyam, Itara Barnes, Cynthia Barton, Dori Bilik, Howard Bregman, Zahid Butt, Jeffrey Clyman, Anne Coultas, Liz Earley, Pavla Frazier, Michelle Hinterberg, Ryan Knepp, Jane Koenig, Joseph Kunisch, Tammy LaFavcr, Rob McClure, Patti McKay, Christopher Moesel, Lisa Nelson, David Nilasena, Vaspaan Patel, Ann Phillips, Kala Ramesh, Stan Rankins, Sophie Scheidlinger, Sharon Sebastian, Julia Skapik, Anne Smith, Dawn Stapleton, Judith Warren, Lori Welsch

Agenda Item	Time/Presenter	Objective	Discussion/Options/Decisions
Participants	2:30 / Balu	Welcome participants	
Nov 19th Meeting Minute Review	2:30 / Balu	Review discussion, decisions, and action items from previous meeting	Summarized last User Group Meeting conversation.
QDM Issue Review	2:35 PM	<u>QDM-87</u> : Ability to refer to immunizations is inconsistent with interoperability standards	<p>It was stated that QRDA currently specifies a short-term work-around for using CVX codes in Medication entries, but CVX codes ideally belong in Immunization entries. MITRE asked if adding a QDM category for Immunization with several datatypes (e.g., <i>recommended</i>, <i>administered</i>, etc.) was needed. Most members agreed it was a good idea and one measure developer stated that she would take a look at vaccination measures to determine what datatypes might be needed. MITRE agreed to look at other frameworks (e.g., FHIR) to see what modes are supported. One participant asked if we should we stay within the Medication category and introduce new datatypes to support immunizations. MITRE stated that the category is only a representational construct. In the implementation guides for HQMF, QRDA, they are all represented as data types, without really classifying them separately.</p> <p>One of the participants stated that the RxNorm template in QRDA was the only deviation from the norm, so why change the entire model. MITRE stated that QDM datatypes can only map to one template each, so Medication</p>

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			<p>datatypes can't map to Medication <i>and</i> Immunization templates. By introducing new Immunization datatypes, we can keep the 1:1 mappings.</p> <p>Another participant stated that C-CDA R2 allows CVX codes in Medication entries, and that QRDA should follow – therefore removing the technical justification for requiring new Immunization datatypes. The participant also stated that CMS guidance explicitly allows for valueset constraints to be overridden in Meaningful Use eCQMs. Therefore, if we are to introduce Immunization datatypes, it should be for other than technical reasons.</p> <p>MITRE suggested that aligning more closely with C-CDA, QRDA, QUICK, and FHIR may already provide enough value to proceed. The user group agreed that there is value in consistency and that we should continue to pursue this. MITRE will come up with draft datatypes for discussion and the group can decide in subsequent conversations whether or not to add a new Immunization category to the QDM.</p>
	3:05 PM	<p><u>QDM-37</u>: Fundamental problem with diagnosis datatypes. ...continued from last UG discussion</p>	<i>(Skipped in order to provide enough time to discuss other agenda items)</i>
	3:35	<p><u>QDM-99</u>: Intent of Diagnosis Datatypes Start Datetime ...related to QDM-37</p>	<p>MITRE explained the current representation of the effective time for Diagnosis start/stop. Used a presentation slide to describe the two “flavors” of representation in current usage and stated that the clinical meaning does not meet the intent of the representation. A participant stated that she interprets the <i>start time</i> to mean the recording time of the provider, never as the <i>onset</i> of the condition.</p>

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			<p>One of the participants referred to a JIRA ticket referencing workflows where the diagnosis is recorded only <i>after</i> the encounter (in which case <i>starts during encounter</i> would not work).</p> <p>Another participant referred to the concept of a <i>working diagnosis</i>; for example, when a patient has symptoms of diabetes, the doctor may work on the assumption of diabetes during the encounter, but it is not a confirmed diagnosis until several days later when the result of a lab test confirms it.</p> <p>Another participant suggested that the primary intent is <i>why did you have this visit?</i> There may be a recorded set of symptoms that lead to a diagnosis, but the primary reason for the visit is usually only found in claims data. Will a doctor leave a chart open in the EHR for three days while waiting for a lab test result, just so he/she can record the Encounter Diagnosis before closing the chart?</p> <p>Another participant suggested that the primary reason for a visit may not always match the principal billing code since the biller may pick a different (but still relevant) code that results in better payment.</p> <p>Yet another participant agreed with all the viewpoints, and stated that using the <i>starts during encounter</i> construct will not work. Despite its issues, claims data link the Encounter to the Diagnosis with no ambiguity.</p> <p>Another participant chimed in stating that there are a lot of related dependencies with C-CDA, and that this is all very complex. When a patient</p>

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			<p>has multiple problems, how do we determine a problem's status of <i>active</i> when it is not the primary diagnosis for the Encounter? Currently, an Encounter activity has within it, an Encounter Diagnosis and will have a time component – a problem observation entry that is wrapped in the Encounter activity.</p> <p>One participant noted that there are situations in some EHRs where the <i>diagnosis</i> is cleared out when the encounter ends. This ensures that an ongoing condition isn't billed in <i>every</i> encounter. If the patient comes back, it is not necessarily in that Encounter. <i>Problems</i>, however, are treated as ongoing and never go away unless a clinician resolves or removes them—but they are not linked to any specific encounter.</p> <p>On the Eligible Hospital side, one clinician stated that sometimes there are diagnoses that are distinct – and not a continuation of the first diagnosis (e.g., AMI). If we are trying to link it to the Encounter, of whether the patient is getting the right treatment or not, we are good at turning Diagnosis 'On', but sometimes we forget to turn it 'Off'. So, <i>Diagnosis, Active</i> may capture diagnoses that are not, in fact, <i>active</i>. Another participant stated that measure developers are sensitive to this and try to account for it.</p> <p>One participant suggested that the overarching problem is that we are in a period of transition. We don't yet encode data for <i>clinical</i> purposes, but rather for billing reasons instead. HITECH is trying to change this, but we are not yet there. In the future, clinicians should always mark the conditions that are being managed during an encounter.</p>

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			<p>MITRE asked if there was an interim solution; whether it be conceding to use billing data, using <i>overlaps</i>, instead of <i>starts during</i>, etc. One of the participants stated that <i>overlaps</i> is still not a good solution since it doesn't really address the reason that the patient had the encounter."</p> <p>In conclusion one of the participants volunteered to map out the care process that occurs and how it corresponds to measurement. This participant will try to leverage the "provider implementation workgroup" from the recently concluded Kaizen meetings and come up with some possible options.</p>
	4:00	QDM-79: Enhance Cumulative Medication Duration Representation	<p>MITRE started by reminding the UG that according to the current QDM spec, CMD for <i>Medication, Active</i> is calculated using <i>order</i> data. Ideally, it should probably be <i>fill</i> data, but <i>fill</i> data is not always available. Order data is always in the EHR, but the same can't be said for fill data. The spec does allow more explicit CMD calculations using order data (CMD on <i>Medication, Order</i>) or fill data (CMD on <i>Medication, Dispensed</i>), but what is the right approach for CMD on <i>Medication, Active</i>?</p> <p>One participant noted that a <i>Medication, Order</i> that was canceled will cause an issue in that CMD will still be calculated against it, even if the intent was <i>not</i> to have the patient on the medication. Fill data would represent only what the patient actually received. Later on, another participant countered that if CMD is based on fill data, a doctor may be penalized for prescriptions he/she never wrote.</p> <p>Another participant stated that using order data for CMD on <i>Medication, Active</i> is not correct according to QMD's definition of <i>Medication, Active</i>, and the fact that all of the corresponding QRDA templates are based on <i>Administration Acts</i> (not <i>Supply Acts</i>).</p> <p>Some participants felt that measure developers should choose (by using <i>Medication, Order</i> or <i>Medication, Dispensed</i>) rather than using <i>Medication, Active</i></p>

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			<p>(which is too ambiguous). One measure developer stated that the original reason they used <i>Medication, Active</i> was to make it clear that they were interested in CMD over the course of multiple dispenses (not just a single dispense). MITRE indicated that the way CMD is represented now, using a SUM operator, it already is an aggregate calculation no matter what the datatype.</p> <p>One of the participants asked whether QRDA should support better pre-processing to get medication data wherever it lives?</p> <p>MITRE asked how QRDA administration acts work in an ambulatory situation? One of the participants answered saying it is what the patient says he is taking or what the doctor intends that they take. When asked about the difference between a doctor's intent and the actual order, the participant indicated that both the supply of the substance and the intent are represented in CDA (via two different entries). The participant also suggested that the HL7 Pharmacy workgroup might be able to add to the conversation.</p> <p>MITRE asked whether we should disallow CMD on the <i>Medication, Active</i> altogether, requiring that more specific datatypes be used. One of the participants stated that she liked the idea of making authors specify what data they want to use. Another measure developer stated that she does not mind going to that level, but clear direction would be good.</p>
		Conclusion	Next QDM User Group meeting will be held January 28st from 2:30-4:30PM EST.
Next steps			<p>Continue to get clarity on Diagnosis data types and linkages to Encounters.</p> <p>One of the participants suggested that only Encounter Diagnosis is missing in the QDM; and whether it was possible to add an Encounter Diagnosis, which might help the alignment.</p>

Action item	Assignee
Map out the care process that currently occurs in care settings with the “Provider implementation workgroup” from the recently concluded Kaizen group and come up with some possible options for representing the intent behind the <i>Diagnosis</i> that is being captured.	Julia Skapik - ONC
Look at current representations of <i>ordered</i> , <i>active</i> and <i>administered</i> in the current <i>vaccination</i> measures	Anne Smith - NCQA
Look at frameworks like FHIR and determine how <i>administered</i> and <i>recommended</i> are supported for immunization.	Chris Moesel – MITRE
Draft data types of immunization for discussion in the next QDM user groups.	Chris Moesel - MITRE